WELCOME TO OUR OFFICE

Personal Information:

Today's Date_____
First Name:_____Last Name: _____Mid.Initial.:_____
Address: _____City, State, Zip:_____
*Email _____ *(*We do not share this email, it is for contacting you only)*
Home Phone: _____ Cell Phone:_____
Sex: Male❑ Female❑
Age: ____ Date of Birth: _____
Occupation:_____
Company/Employer's Name: _____
Work Phone: _____
Married❑ Single❑ Separated❑ Divorced❑ Widowed❑ Minor❑ Partnered ❑
Spouse's Name: _____
Emergency Contact: Name_____ Relationship_____ Phone #_____

Insurance Information:

PRIMARY INSURANCE COMPANY: _____
Policy Number: _____ Copied For File❑
Group Number: _____
Is this Insurance in your name: Yes❑ No ❑
If no, Who's name is on the card: _____
How are they related to you: Spouse❑ Mother❑ Father❑ Child❑ Dependent❑
What is their date of birth: _____

Are you covered by an additional insurance: No❑ Yes❑ (If yes, please fill out below)
SECONDARY INSURANCE COMPANY: _____ Copied For File❑
Policy Number: _____
Group Number: _____
Is this Insurance in your name: Yes❑ No ❑
If no, who's name is on the card: _____
How are they related to you: Spouse❑ Mother❑ Father❑ Child❑ Dependent❑
What is their date of birth: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents have insurance coverage with the insurance company(ies) listed above and assign directly to Dr. Scott Duca all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will remain in effect as long as I remain a patient.

Signature:_____ **Date:** _____
(Patient, Parent, Guardian or Personal Representative)

Print your Name:_____ **Relationship to Patient:** _____
(Patient, Parent, Guardian or Personal Representative)

Patient Condition

Reason for Visit _____

When did your symptoms 1st appear? _____

Is this condition getting progressively worse? Yes❑ No ❑ Unknown ❑

Is this condition due to an accident? Yes❑ No ❑
If yes, what type of accident? Auto❑ Work ❑ Home❑ Other ❑ _____

Does this problem bother you every day? Yes❑ No ❑
If <u>NO</u>, how often does it bother you?
Every other day❑ 2 to 3 days a week❑ about once a week ❑ 2 to 3 times a month❑ once a month❑
Other ❑ _____

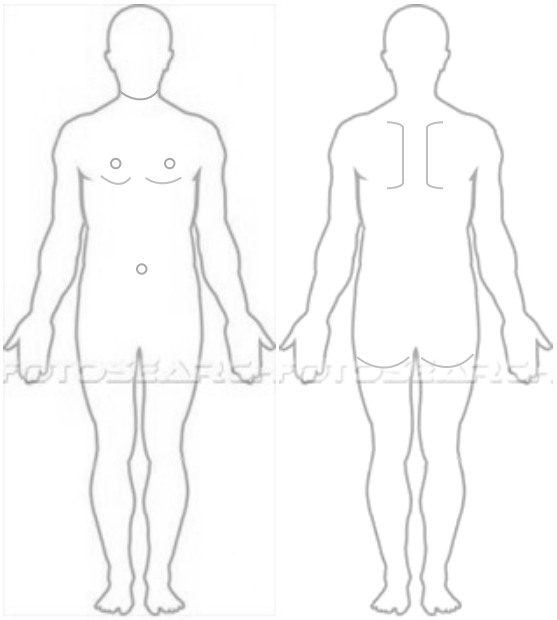
What percentage of the day when you are awake does it bother you?
Up to 1/4 of awake time❑ 1/4 to 1/2 of awake time ❑ 1/2 to 3/4 of awake time ❑ Most all the time❑

Does this problem interfere with any of the following? (check all that apply)
Work❑ Sleep ❑ Daily routine ❑ Recreation❑ Driving a car ❑

What activities or movements are painful to perform? (check all that apply)
Sitting❑ Standing ❑ Walking ❑ Bending❑ Lying Down ❑

Mark the diagram below, where you are experiencing any pain, numbness or tingling…….

FRONT BACK



Rate your Level of Pain on a Scale from 1-10 (10 Being the Worst) _____

HEALTH HISTORY

What Treatments have you already received for this condition?

None❑ Medication ❑ Surgery ❑ Physical Therapy❑ Chiropractor❑ Other❑ _____

Date of Last: Physical Exam _____ X-Ray _____ MRI/CT Scan _____

Name and address of other doctor(s) who have treated you for your condition:

_____

_____

Personal Health History

Please mark "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	No ❑	Yes ❑	Anemia	No ❑	Yes ❑	Anorexia	No ❑	Yes ❑
Appendicitis	No ❑	Yes ❑	Heart Disease	No ❑	Yes ❑			
Arthritis	No ❑	Yes ❑	(Osteoarthritis And/ Or Rheumatoid)					
Asthma	No ❑	Yes ❑	Bleeding	No ❑	Yes ❑	Breast Lumps	No ❑	Yes ❑
Bulimia	No ❑	Yes ❑	Cancer	No ❑	Yes ❑	Bronchitis	No ❑	Yes ❑
Cataracts	No ❑	Yes ❑	Chem Depend	No ❑	Yes ❑	Chicken Pox	No ❑	Yes ❑
Diabetes	No ❑	Yes ❑	Emphazema	No ❑	Yes ❑	Epilepsy	No ❑	Yes ❑
Goiter	No ❑	Yes ❑	Gonorrhea	No ❑	Yes ❑	Gout	No ❑	Yes❑
Headaches	No ❑	Yes ❑	Heart Disease	No ❑	Yes ❑	Hepatitis	No ❑	Yes ❑
Hernia	No ❑	Yes ❑	Herniated Disk	No ❑	Yes ❑	Herpes	No ❑	Yes ❑
High Blood Pres.	No ❑	Yes ❑	High Cholesterol	No ❑	Yes ❑	Kidney Disease	No ❑	Yes ❑
Liver Disease	No ❑	Yes ❑	Measles	No ❑	Yes ❑	Migraines	No ❑	Yes❑
Mononucleosis	No ❑	Yes ❑	Multiple Sclerosis	No ❑	Yes ❑	Mumps	No ❑	Yes ❑
Osteoporosis	No ❑	Yes ❑	Pacemaker	No ❑	Yes ❑	Parkinson's	No ❑	Yes ❑
Pinched Nerve	No ❑	Yes ❑	Pneumonia	No ❑	Yes ❑	Polio	No ❑	Yes ❑
Prostate Issues	No ❑	Yes ❑	Prosthetic Limbs	No ❑	Yes ❑	Psychiatric Care	No ❑	Yes ❑
Rheumatic Fever	No ❑	Yes ❑	Scarlet Fever	No ❑	Yes ❑	Sexual Diseases	No ❑	Yes ❑
Sleep Disorders	No ❑	Yes ❑	CPAP or Meds (Ambien/Lunesta, etc)			Stroke	No ❑	Yes ❑
Suicide Attempts	No ❑	Yes ❑	Thyroid Problems	No ❑	Yes ❑	Ulcers	No ❑	Yes ❑
Vaginal Infections	No ❑	Yes ❑	Whopping Cough	No ❑	Yes ❑			

Personal/Social History

Pregnant? No ❑ Yes ❑ Due Date: _____

O.B. Dr.'s Name: _____ Office: _____ Phone #: _____

Exercise	None ❑	Running ❑	Weights ❑	Yoga ❑	Walking ❑	Biking ❑	Sports ❑
Work Activity	Desk Job ❑	Standing Job ❑	Light Labor ❑	Heavy Labor ❑			
Drink	No ❑	Yes ❑	Daily ❑	Weekly ❑	Weekends ❑	only once in awhile ❑	
Smoke	No ❑	Yes ❑	Daily ❑	Weekly ❑	Weekends ❑	only once in awhile ❑	
High Stress	No ❑	Yes ❑	School ❑	Work ❑	Family ❑	Personal Make-up ❑	Other ❑_____

Previous Injuries/Surgeries

Please list any Injuries/Surgeries you have had with a brief description:

Head Injuries _____ Date: _____

Falls _____ Date: _____

Broken Bones _____ Date: _____

Dislocations _____ Date: _____

Surgeries _____ Date: _____

Assignment, Lien and Authorization of Insurance Benefits and Attorney

Duca Chiropractic, Inc. d/b/a Back On Track Chiropractic
225 Lakeshore Parkway-Suite 101
Homewood, Alabama 35209
Phone: 205-942-4243 Fax: 205-942-9091

To whom it concerns,

I hereby authorize and direct you, (a third party insurance company, my insurance company and/or my attorney) to pay directly to DUCA CHIROPRACTIC, INC. d/b/a BACK ON TRACK CHIROPRACTIC, located at 225 Lakeshore Parkway #101 Homewood, Alabama 35209, such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness and by reason of any other bills that are due at this office, and to withhold such sums from any disability benefits, medical benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and all my proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. In addition, I request and authorize payments be sent directly to this office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due to the office for their services as well as court cost and attorney fees, if needed for collection. I further understand and agree that this assignment, Lien and Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned office be given the power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

Patient Name: (Printed) _____ Date: _____
Patient Name: (Signed) _____
Address: _____City: _____State: _____Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Witness: _____

For Adjuster and/or Attorney use Only:

Insurance Company, Adjuster and/or Attorney:

Please sign, date and return this document to the following doctor's office:

Duca Chiropractic, Inc. d/b/a Back On Track Chiropractic
225 Lakeshore Parkway-Suite 101
Homewood, Alabama 35209
Phone: 205-942-4243 Fax: 205-942-9091

The undersigned does hereby agree to observe all the terms and conditions of the above lien and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the said doctor's office name above.

Name: (printed) _____ Date: _____
Signature: _____Date:_____

DUCA CHIROPRACTIC, INC
DBA BACK ON TRACK CHIROPRACTIC
PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENTAND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent.

The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; b) an email sent to the address provided by me; c) telephoning my cell or home and leaving a message on my voicemail or answering machine or with the individual answering the phone d) telephoning my office and leaving a message on my personal voicemail box if available. (We <u>will not</u> leave a message with any other individual that may answer the phone or public answering machine that is not personalized for you only.)

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual or Legal Representative

Date Signed ____/____/____ Witness: _____

Patient's Name:_____ **Today's Date:** _____

NECK DISABILTY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. PLEASE ANSWER EVERY SECTION and in each section choose ONLY ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which MOST CLOSELY describes your problem.

Section 1 -Pain Intensity
- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights from the floor But I can lift them if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage Light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights
- ❑ I cannot lift or carry anything at all.

Section 4 - Reading
- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all

Section 5 - Headaches
- ❑ I have no headaches at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have slight headaches which come frequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Section 6 - Concentration
- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating when I want to.
- ❑ I have a lot of difficulty concentrating when I want to.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I cannot concentrate at all.

Section 7 - Work
- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Section 8 – Driving
- ❑ I drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight neck pain.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I can't drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive my car because of moderate neck pain.
- ❑ I can't drive my car at all.

Section 9 - Sleeping
- ❑ I have no trouble sleeping..
- ❑ My sleep is slightly disturbed (Less than 1 hr sleepless).
- ❑ My sleep is moderately disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-4 hours sleepless).
- ❑ My sleep is greatly disturbed (3-4 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation
- ❑ I can engage in all recreational activities with no pain.
- ❑ I can engage in all recreational activities with some neck pain.
- ❑ I can engage in most but not all recreational activities b/c pain
- ❑ I can engage in a few of my recreational activities with pain.
- ❑ I can hardly do any recreational activities because of the pain.
- ❑ I can't do any recreational activities at all..

Additional Comments: _____

I attest that these answers are a current representation of my degree of pain as of today!

Patient Signature _____ Today's Date: _____

OFFICE USE ONLY

Questions are scored on a vertical scale of 0-5. Total score is multiplied by 2. Divide by the number of sections answered, multiplied by 10. A total score of 22% or more is considered significant activities of daily living disability.

(Score _____ x 2) / (_____ Sections x 10) = _____ %ADL

Additional Comments: _____

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name:_____ **Today's Date:** _____

LOW BACK DISABILTY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. PLEASE ANSWER EVERY SECTION and in each section choose ONLY ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which MOST CLOSELY describes your problem.

Section 1 -Pain Intensity
- ❑ I can tolerate the pain without having to use pain killers.
- ❑ The pain is bad but I can manage without taking pain killers.
- ❑ Pain killers give me complete relief from pain.
- ❑ Pain killers give me moderate relief from pain.
- ❑ Pain killers give me very little relief from pain killers.
- ❑ Pain killers give me no relief and I do not use them.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights from the floor But I can lift them if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage Light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights .
- ❑ I cannot lift or carry anything at all.

Section 4 - Walking
- ❑ Pain does not prevent me from walking.
- ❑ Pain prevents me from walking more than 1 mile.
- ❑ Pain prevents me from walking more than one-half mile.
- ❑ Pain prevents me from walking more than one-quarter mile.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting longer than 1 hour.
- ❑ Pain prevents me from sitting longer than 30 minutes.
- ❑ Pain prevents me from sitting longer than 10 minutes.
- ❑ Pain prevents me from sitting almost all of the time.

Section 6 - Standing
- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing more than 30 minutes.
- ❑ Pain prevents me from standing more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 - Sleeping
- ❑ Pain does not prevent me from sleeping well.
- ❑ I can sleep well, only by using tablets.
- ❑ Even with tablets I have less than 6 hours sleep.
- ❑ Even with tablets I have less than 4 hours sleep.
- ❑ Even with tablets I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Social Life
- ❑ My social life is normal and does not give me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests (ex. Dancing)
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have no social life because of the pain.

Section 9 - Traveling
- ❑ I can travel anywhere without extra pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage trips over 2 hours.
- ❑ Pain is bad but I manage trips less than 1 hour.
- ❑ Pain restricts me to short trips of under 30 minutes.
- ❑ Pain prevents me from traveling except to the Dr or Hospital.

Section 10 – Changing degree of pain
- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

Additional Comments: _____

I attest that these answers are a current representation of my degree of pain as of today!

Patient Signature _____ Today's Date: _____

OFFICE USE ONLY

Questions are scored on a vertical scale of 0-5. Total score is multiplied by 2. Divide by the number of sections answered, multiplied by 10. A total score of 22% or more is considered significant activities of daily living disability.

(Score _____ x 2) / (_____ Sections x 10) = _____ %ADL

Additional Comments: _____

Reference: Fairbank,Physiotherapy 1981;66(8): 271-3, Hudson-Cook.
In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education, Manchester Univ Press, Manchester 1989: 187-204